

1 EDMUND G. BROWN JR., Attorney General  
of the State of California  
2 GLORIA A. BARRIOS  
Supervising Deputy Attorney General  
3 KIMBERLEY J. BAKER-GUILLEMET, State Bar No. 242920  
Deputy Attorney General  
4 300 So. Spring Street, Suite 1702  
Los Angeles, CA 90013  
5 Telephone: (213) 897-2533  
Facsimile: (213) 897-2804  
6 Attorneys for Complainant

7  
8 **BEFORE THE**  
**BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. PT-2007-742

12 SEAN LOPEZ-WOOD  
13 13176 Spire Circle  
Chino Hills, California 91709

**A C C U S A T I O N**

14 Psychiatric Technician License No. PT 31711  
Respondent.

15  
16 Complainant alleges:

17 **PARTIES**

- 18 1. Teresa Bello-Jones, J.D., M.S.N., R.N. (Complainant) brings this  
19 Accusation solely in her official capacity as the Executive Officer of the Board of Vocational  
20 Nursing and Psychiatric Technicians (Board).  
21 2. On or about May 8, 2003, the Board issued Psychiatric Technician License  
22 Number PT 31711 to Sean M. Lopez-Wood (Respondent). The Psychiatric Technician License  
23 was in full force and effect at all times relevant to the charges brought herein and will expire on  
24 June 30, 2010, unless renewed.

25 **JURISDICTION**

- 26 3. This Accusation is brought before the Board, under the authority of the  
27 following laws. All section references are to the Business and Professions Code unless otherwise  
28 indicated.

1                   4.       Section 4521 of the Code states, in pertinent part that:

2                   "The board may suspend or revoke a license issued under this chapter [the  
3       Psychiatric Technicians Law (Bus. & Prof Code, 4500, et seq.))] for any of the following reasons:

4                   "(a) Unprofessional conduct, which includes but is not limited to any of the  
5       following:

6                   "    (1) Incompetence or gross negligence in carrying out usual psychiatric  
7       technician functions.

8                   ...

9                   "(n) The commission of any act involving dishonesty, when that action is  
10       substantially related to the duties and functions of the licensee.

11                   "(o) Except for good cause, the knowing failure to protect patients by failing to  
12       follow infection control guidelines, thereby risking transmission of blood-borne infectious  
13       diseases from licensee to patient, from patient to patient, and from patient to licensee. In  
14       administering this subdivision, the board shall consider the standards, regulations, and guidelines  
15       of the State Department of Health Services developed pursuant to Section 1250.11 of the Health  
16       and Safety Code and the standards, guidelines, and regulations pursuant to the California  
17       Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of  
18       Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other  
19       blood-borne pathogens in health care settings. As necessary, the board shall consult with the  
20       California Medical Board, the Board of Dental Examiners, and the Board of Registered Nursing,  
21       to encourage appropriate consistency in the implementation of this section. The board shall seek  
22       to ensure that licentiates and others regulated by the board are informed of the responsibility of  
23       licentiates and others to follow infection control guidelines, and of the most recent scientifically  
24       recognized safeguards for minimizing the risk of transmission of blood-borne infectious  
25       diseases."

26                   5.       Section 2577 of title 16 of the California Code of Regulations states:

27                   "As set forth in Section 4521 of the code, gross negligence is deemed unprofessional conduct and  
28       is grounds for disciplinary action. As used in Section 4521 'gross negligence' means a substantial

1 departure from the standard of care which, under similar circumstances, would have ordinarily  
2 been exercised by a competent licensed psychiatric technician, and which has or could have  
3 resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief  
4 that there was a conscious disregard or indifference for the health, safety, or welfare of the  
5 consumer shall be considered a substantial departure from the above standard care."

6           6.       Section 2577.1 of title 16 of the California Code of Regulations states:  
7 "As set forth in Section 4521 of the code, incompetence is deemed unprofessional conduct and is  
8 grounds for disciplinary action. As used in Section 4521, 'incompetence' means the lack of  
9 possession of and the failure to exercise that degree of learning, skill, care and experience  
10 ordinarily possessed and exercised by responsible licensed psychiatric technicians."

11           7.       Section 2576.6 of title 16 of the California Code of Regulations states, in  
12 pertinent part that:

13                   "(a) A licensed psychiatric technician shall safeguard patients'/clients' health and  
14 safety by actions that include but are not limited to the following:

15                   ....  
16                   "(2) Documenting patient/client care in accordance with standards of the  
17 profession; and

18                   ....  
19                   "(b) A licensed psychiatric technician shall adhere to standards of the profession  
20 and shall incorporate ethical and behavioral standards of professional practice which include but  
21 are not limited to the following:

22                   "(1) Maintaining current knowledge and skills for safe and competent practice"

23           8.       Section 2576.5 of title 16 of the California Code of Regulations states  
24 that:

25                   "The licensed psychiatric technician performs services requiring technical and  
26 manual skills which include the following:

27                   "(a) Uses and practices basic assessment (data collection), participates in  
28 planning, executes interventions in accordance with the care plan or treatment plan, and

1 contributes to evaluation of individualized interventions related to the care plan or treatment plan.

2           “(b) Provides direct patient/client care by which the licensee:

3           “(1) Performs basic nursing services as defined in subdivision (a);

4           “(2) Administers medications;

5           “(3) Applies communication skills for the purpose of patient/client care and  
6 education; and

7           “(4) Contributes to the development and implementation of a teaching plan related  
8 to self-care for the patient/client.”

9           9.       Section 125.3 of the Code provides, in pertinent part, that the Board may  
10 request the administrative law judge to direct a licensee found to have committed a violation or  
11 violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation  
12 and enforcement of the case.

13           10.     Section 118, subdivision (b) of the Code states:

14           “(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a  
15 board in the department, or its suspension, forfeiture, or cancellation by order of the board or by  
16 order of a court of law, or its surrender without the written consent of the board, shall not, during  
17 any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its  
18 authority to institute or continue a disciplinary proceeding against the licensee upon any ground  
19 provided by law or to enter an order suspending or revoking the license or otherwise taking  
20 disciplinary action against the licensee on any such ground.”

#### 21                               **FIRST CAUSE FOR DISCIPLINE**

#### 22                               **(Unprofessional Conduct: Gross Negligence)**

23           11.     Respondent is subject to disciplinary action under section 4521  
24 subdivision (a)(1) of the Code for unprofessional conduct and gross negligence as defined by  
25 California Code of Regulations, title 16, section 2577, in that he substantially departed from the  
26 standard of care which, under similar circumstances, would have ordinarily been exercised by a  
27 competent licensed psychiatric technician, and which resulted in harm to a Patient Fernando F.  
28 on August 31, 2005, as follows:

1           a.     While assigned to "Rounds" duty Respondent failed to ensure the safety  
2 and supervision of the patients on the unit.

3           b.     Respondent failed to account for all patients upon return from a patio  
4 break, in violation of facility policy.

5           c.     Respondent failed to document the location of each patient on the secure  
6 unit thereby allowing the risk of injury, in violation of facility policy.

7           d.     Respondent failed to safeguard all of the patients on the unit.

8           12.    The circumstances are as follows:

9           a.     On August 31, 2005, Respondent was assigned to hourly rounds on the  
10 AM shift on a secure unit at Metropolitan State Hospital where he was employed as a Psychiatric  
11 Technician. In this capacity, Respondent was charged with utilizing the legend provided on  
12 Rounds Record and documenting the following on the Rounds Records: patients' whereabouts  
13 every hour, when patients leave to and return from patio breaks, clinic appointments, court  
14 hearings, school, etc. and the amount of meals consumed by patients. Respondent was also  
15 responsible for completing the final check of the patio which includes checking that all doors and  
16 gates are locked and in good repair, ensuring that there is no contraband present and confirming  
17 that the area is secure and all individuals are accounted for.

18           b.     At approximately 1605 hours patient Fernando F. was discovered  
19 unaccounted for on the unit. According to the Rounds Record, Respondent indicated that  
20 Fernando F. was on the unit at 1300 hours following a patio break at 1230 hours. Respondent  
21 did not indicate in the Rounds Record whether Fernando F. was on the unit at 1400 hours. At the  
22 end of Respondent's shift, the PM staff member assigned to hourly rounds asked Respondent,  
23 "Where is Fernando?" Despite the fact that Respondent had accounted for Fernando initially  
24 being present on the unit, he replied, "He is at school."

25           c.     It was determined that Respondent had left the facility and was absent  
26 without leave (AWOL). Hospital staff was unable to determine the exact time when or the  
27 location where Fernando F. had gone AWOL because Respondent had not completed the Rounds  
28 Record correctly and in accordance with policy. After it was determined that Fernando F. was

1 missing, an inspection of the patio area revealed that the fence had been kicked out and that the  
2 storage closet was open. Respondent failed to notice this when he completed the patio check that  
3 day.

4 d. Respondent's supervisor, Joyti Scott, R.N., reviewed the Rounds Record  
5 and discovered that Respondent had not followed the legend in making notations as to when  
6 individuals went to the patio and returned to the unit. As a result, Respondent was unable to  
7 verify if Fernando F. ever returned to the unit from the patio. Supervisor Scott also determined  
8 that Respondent left 30 blank boxes on the rounds record and only accounted for four (4)  
9 individuals at 1300 hours. The rounds record was left completely blank for the 1400 hours  
10 rounds. Further, Respondent failed to indicate the amount of lunch consumed by any of the  
11 patients on the rounds records for that day.

12 e. On September 1, 2005, Nurse Scott questioned Respondent as to whether  
13 he had visually accounted for Fernando F. during the time period in question. Respondent's  
14 reply was, "I thought I saw him."

15 f. On September 21, 2005, Respondent was counseled by Nurse Scott  
16 regarding the incident involving patient Fernando F. on August 31, 2005. Respondent was  
17 reprimanded for failing to adhere to the following policies: Metropolitan State Hospital  
18 Administrative Manual AD No. 3209 "Patient Count", Nursing Policy/Procedure Manual  
19 (NP&P) 709 "Patient Rounds/Patient Count" and Nursing Policy/Procedure Manual (NP&P) 708  
20 "Supervision of Patients During Patio Activities." Respondent was reminded that on November  
21 16, 2004, he had signed a training record indicating that he had read and understood the intent of  
22 policies related to patient supervision.

23 13. Respondent is subject to disciplinary action under section 4521  
24 subdivision (a)(1) of the Code as defined by California Code of Regulations, title 16, section  
25 2577, in that he substantially departed from the standard of care which, under similar  
26 circumstances, would have ordinarily been exercised by a competent licensed psychiatric  
27 technician, and which could have resulted in harm to patients. Specifically, on June 2, 2005, and  
28 on September 15, 2005, Respondent failed to follow aseptic procedures while administering

1 medications to patients thereby potentiating the introduction of unprescribed agents to patients.

2 14. The circumstances are as follows:

3 a. On June 2, 2005, Respondent was observed passing medication by Mary  
4 Elmgren, Registered Nurse and Nursing Instructor. During the observation, Nurse Elmgren  
5 noticed that Respondent failed to wash his hands throughout the entire process and failed to  
6 check the medication against the Medication Treatment Record (MTR) three (3) times to ensure  
7 the right medication was being administered. Further, Respondent was unable to describe the  
8 therapeutic effects of drugs administered, was unable to apply the principles of asepsis to  
9 medication administration, failed to adhere to hospital policy when wasting medication, failed to  
10 sign out narcotics correctly and failed to properly store items in clearly marked areas of the  
11 medication cart. Nurse Elmgren recorded these observations on a "Medication Administration  
12 Monitoring Tool" dated June 2, 2005.

13 b. As a result of this observation, on June 9, 2005, Willie Cottens, Senior  
14 Psychiatric Technician (SPT), reviewed Medication Administration with Respondent.

15 c. On June 10, 2005, Nurse Joyti Scott, emphasized the importance of  
16 following policies and procedures with Respondent.

17 d. On September 15, 2005, Respondent was observed passing medications by  
18 SPT Willie Cottens. On that date SPT Cottens observed that Respondent still failed to  
19 consistently check the medication against the MTR three (3) times to ensure the right medication  
20 was being administered. In addition, Respondent was still unable to describe therapeutic effects  
21 of medications being administered and was unable to differentiate expected side effects from  
22 adverse reactions. SPT Cottens recorded these observations on a "Medication Administration  
23 Monitoring Tool" dated September 15, 2005.

24 **SECOND CAUSE FOR DISCIPLINE**

25 **(Unprofessional Conduct: Incompetence)**

26 15. Respondent is subject to disciplinary action under section 4521  
27 subdivision (a)(1) of the Code for unprofessional conduct and incompetence as defined by  
28 California Code of Regulations, title 16, section 2577.1, in that he lacked possession of and

1 failed to exercise that degree of learning, skill, care and experience ordinarily possessed and  
2 exercised by responsible licensed psychiatric technicians. Complainant refers to, and by this  
3 reference incorporates the allegations set forth above in paragraphs 11, 12, 13 and 14, inclusive,  
4 as though set forth fully.

### 5 THIRD CAUSE FOR DISCIPLINE

#### 6 (Commission of Any Act Involving Dishonesty)

7 16. Respondent is subject to disciplinary action under section 4521  
8 subdivision (n) in that he committed an act of dishonesty on August 31, 2005, when he  
9 misrepresented to the PM staff that Fernando F. was at school when he had accounted for  
10 Fernando initially being present on the unit. Complainant refers to, and by this reference  
11 incorporates the allegations set forth above in paragraphs 11 and 12, inclusive, as though set forth  
12 fully.

### 13 FOURTH CAUSE FOR DISCIPLINE

#### 14 (Knowing Failure to Follow Infection Control Guidelines)

15 17. Respondent is subject to disciplinary action under section 4521  
16 subdivision (o) in that he failed to follow infection control guidelines while administering  
17 medications to patients on more than one occasion. Complainant refers to, and by this reference  
18 incorporates the allegations set forth above in paragraphs 13 and 14, inclusive, as though set forth  
19 fully.

### 20 FIFTH CAUSE FOR DISCIPLINE

#### 21 (Failure to Safeguard Patients' Health and Safety)

22 18. Respondent is subject to disciplinary action under section under section  
23 2576.6, subdivision (a)(2) of the California Code of Regulations in that he failed to document  
24 patient care in accordance with the standards of the profession. Complainant refers to, and by  
25 this reference incorporates the allegations set forth above in paragraphs 11, 12, 13 and 14,  
26 inclusive, as though set forth fully.

27 ///

28 ///

1 and to maintain compliance with licensing and other standards. Respondent was again informed  
2 that he was using sick leave credits at a faster rate than he was earning them. Respondent was  
3 also given a counseling action plan.

4 PRAYER

5 WHEREFORE, Complainant requests that a hearing be held on the matters herein  
6 alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric  
7 Technicians issue a decision:

- 8 1. Revoking or suspending Psychiatric Technician License Number PT  
9 31711, issued to Sean M. Lopez-Wood.
- 10 2. Ordering Sean M. Lopez-Wood to pay the Board of Vocational Nursing  
11 and Psychiatric Technicians the reasonable costs of the investigation and enforcement of this  
12 case, pursuant to Business and Professions Code section 125.3;
- 13 3. Taking such other and further action as deemed necessary and proper.

14  
15 DATED: March 17, 2009

16  
17 

18 TERESA BELLO-JONES, J.D., M.S.N., R.N.  
19 Executive Officer  
20 Board of Vocational Nursing and Psychiatric Technicians  
21 State of California  
22 Complainant

23 LA2008601118

24 60381497.wpd